CONFIDENTIAL SBIRT Referral – SCDMH/Community Mental Health Center

Date:	Medicaid #:
Referral Source Contact Information:	
Name:	
Company/Organization:	
Telephone #:	Fax #:
Client Information:	
Name:	
Address:	
Telephone #:	
Reason for Referral:	
	☐ Positive Mental Health Filtering Response (complete back of form)
	☐ Meets criteria for both Mental Health Filtering Response and Substance Abuse Disorder
	☐ Client requested assistance
	☐ Other (Specify):
Note: *Call the SBIRT Community Mental Health Center Referral staff as indicated on the CMHC Point of Contact List to set up an appointment for intake assessment. Fax this form to the CMHC point of contact.*	
Community Mental Health Center Name:	
Point of Contact Name:	
Point of Contact Phone /Fax #:	
Comment:	

CONFIDENTIAL Mental Health Filtering Questions
SBIRT Referral

Date: ____________________

Client Name:		Telephone #: ( )
Address:	City/State:	Zip Code:

(To be completed by MHN or provider screening personnel.)

Mental Health (Circle response)

1) Have you *ever* been a client of a psychiatrist, psychologist, therapist, or counselor for an emotional problem?	Yes	No
a) List professional and type and when service provided. b) Are you currently a client at a local community mental health center?		
2) In the last year, have you taken any psychiatric medications to control emotional symptoms?	Yes	No
a) Type of medication(s) and strength:		
3) Have you ever been admitted to a hospital for mental health problems?	Yes	No
a) List the hospital, when, and for what reason.		
4) Have you *ever* heard voices no one else could hear or seen objects or things which others could not see?	Yes	No
5) In the last three months, have you had thoughts about hurting yourself or someone else?	Yes	No
a) Do you have a plan?	Yes	No

Positive response to any items may indicate need for further screening, assessment and psychiatric evaluation.

Comments: